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ABSTRACT

Obesity is one of the most prevalent health concerns currently facing industrialized nations. Psychological, social and emotional problems result from excess weight, and those who fail in their weight-loss efforts become extremely depressed. The obsession to be thin, particularly in the United States, is a boon to weight-control programs, both legitimate and fraudulent. Counselors can have a positive and reinforcing role in weight-reduction programs which combine general group support with behavior modification techniques. This monograph includes: (1) strategies counselors can use with clients; (2) self-management techniques to be practiced by individuals; (3) problems with various age groups and special populations; and (4) dieting "myths" and problems associated with both failure and success in losing weight. Dieting tips are provided and appendices include usable charts and records, a food exchange diet and an extensive list of food exchanges. Schools and community agencies are suggested as ideal locations for structured weight-control programs. (Author/KMF)

Counseling Overweight People

by

Robert D. Voogt

The National Institute of Education

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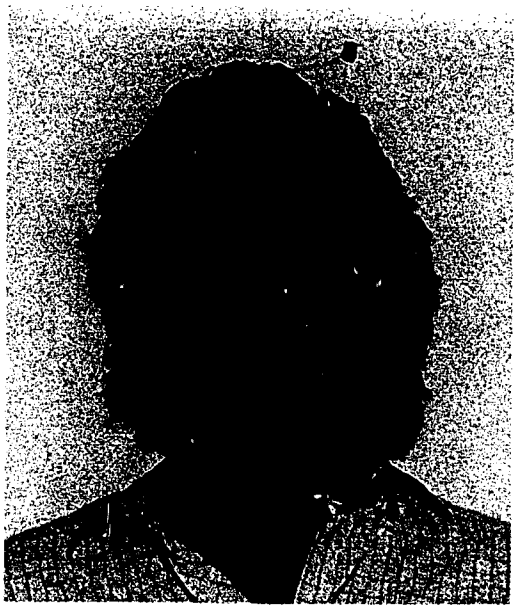

Robert D. Voogt earned his Ph.D. at The University of Michigan in 1978 under Dr. Garry R. Walz (Director of the ERIC/CAPS Clearinghouse). Until September 1, 1980, he was Assistant Professor at the Louisiana State University Medical Center in New Orleans, teaching in the Department of Rehabilitation Counseling and carrying a caseload of 40 clients. During the summer of 1979 Dr. Voogt was a Fellow for the National Endowment for the Humanities in Medical Ethics. As of September 1, 1980, he officially retired from paid employment, and intends to spend the next two years traveling in the United States and living on freighters as he explores other countries.

Readers will be interested to know that Bob weighed 250 pounds before beginning graduate school, became involved in a behavioral-control weight reduction program, and is now a trim 160 pounds. He knows whereof he speaks!

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Obesity is one of the most prevalent health concerns currently facing industrialized nations. Psychological, social, and emotional problems result from excess weight, and those who fail in their weight-loss efforts become extremely depressed. The obsession to be thin, particularly in the United States, is a boon to weight-control programs, both legitimate and fraudulent. Counselors can have a positive and reinforcing role in weight-reduction programs which combine general group support with behavior modification techniques. This monograph presents a variety of strategies that counselors can use with clients either individually or in groups, as well as self-management techniques to be practiced by individuals. The author suggests that schools and community agencies are ideal locations for structured weight-control programs. Since obesity problems vary according to age and ethnic groups, counselors should gather all available information about the cultural, economic, and physical conditions that play a part in the dietary habits of their clients. The paper speaks briefly about dieting "myths" and problems associated with both failure and success in losing weight. In both instances, counselors can provide support for a vulnerable psyche.

COUNSELING OVERWEIGHT PEOPLE

Robert D. Voogt

As the counseling profession looks to the future, new and emerging client needs bring with them new roles for counselors. One need which has been present for some time but has not been treated adequately is counseling the overweight population.

The Public Health Service considers obesity to be one of the most prevalent health concerns facing the United States and other industrial societies. Blackburn (1977) estimates that at least 60 million Americans consider themselves obese. He states that although Americans are presently spending ten billion dollars per year in an attempt to solve this problem, they are practicing serious and long-term efforts at weight control at only a minimal level. Because of this, the physical and mental health concerns associated with obesity continue to prevail.

In recent years people have developed a new consciousness about their physical appearance and the general well-being of their bodies and minds. Individuals have been slowly putting on weight for a long time, and many found in the past that excess weight was acceptable and even at times desirable. At the present time, however, the thin look--the slender physique--is what is considered to be most desirable. This obviously causes great concern for individuals who desire to appear slender in the eyes of a population with such expectations. Consciousness-raising groups have thus been developed to explore what it is like to be fat in a thin-oriented society, and to teach group members that being fat is one of many choices a person may make (Flack & Grayer, 1975).

Because the act of overeating which produces the excessive caloric intake that causes obesity has occurred so frequently in the past, however, the habit is well-learned and not easily modified (Greenberg, 1977).

A vast number of problems can occur as the result of being overweight. Physiological health aspects of an overweight condition include cardiovascular problems, muscular and skeletal problems, metabolic problems, diabetes, and early mortality. The emotional and social costs of obesity tend also to be extensive. For example, many obese individuals experience anxiety and depression as the result of a perceived threat of being disliked or rejected. They frequently suffer from low self-esteem and lack self-confidence, and they tend not to participate in active sports or in many social events (Jeffrey & Katz, 1977).

The career development of this population suffers as well. Employers often discriminate against them in the hiring process as they feel that the presence of an overweight individual detracts from the image the employer is attempting to convey. At times, members of this population are unable to perform certain job functions because of their overweight condition. A study reported by Roe (1975) examined common health disabilities which kept many individuals on welfare and out of the job market. Obesity was one of the more common disabilities. With the introduction of a health intervention model that helped individuals to lose weight as well as relieving other health problems, these individuals became employed.

According to Canning and Mayer (1966), school counselors are less apt to write reference letters for students who are obese, even

though their intelligence scores and grades are the same as those of their nonobese classmates, thus making it less likely for them to enter colleges with competitive admission standards. Research still needs to be undertaken to explore the relationship between body size and career choice. It is clear from the studies cited, however, that obesity and the overweight condition has become a handicapping issue for many individuals as they plan their life work activities.

While the problem of obesity in the United States is ubiquitous, its etiology remains obscure. Theories attempting to explain the causes of obesity include the psychological, endocrinological, social, neurological, behavioral, and genetic factors. Mayer (1968) concludes after reviewing the varied explanations of obesity that whatever the predisposing factor, almost all overweight individuals have in common one main pattern: They have either an excessive caloric intake or a deficient level of energy expenditure, or a combination of both. This pattern needs to be interrupted for weight loss to occur.

The present era of quick-cure, self-help, and crash programs has had an effect on weight control. Just as some would have us believe that by reading a book we can cure our own maladjusted behaviors, others claim that individuals can lose weight without really trying and even without giving up any calories. Among the conglomerate of solutions to weight problems continually presented to the American public are "get-slim-quick" plans (30 pounds in 30 days), gadgets, pills, shots, and magical potions, most of which fail to work and often are dangerous both physically and mentally. According to Jeffrey and Katz (1977), obsession with the thin look drives individuals to try new techniques which typically have no

scientific basis of support. When these techniques fail, individuals desiring to lose weight become even further depressed.

With the evidence as to how many people consider themselves to be obese, as well as the amount of effort and money being spent to find a magical cure, it appears that counselors can play an important role in meeting the needs of this client population. The problem is not that clients have failed to ask for help. A look at the attendance at weight-control groups provides evidence of the large number of individuals desiring to change their life-style. Organizations such as Take Off Pounds Sensibly (T.O.P.S.) and Weight Watchers have little trouble attracting clients. The problem is that the long-term success rate of these programs is not significant. Therefore, most obese people need more help than these programs can give, and it is the responsibility of us as counselors to respond to their need for services.

Role of the Counselor

The obvious question is what the role of the counselor should be in a weight-control program. While self-help behavior modification has been pushed extensively in the popular press, most of the research demonstrates the importance of an external reinforcer in achieving successful weight reduction (Jeffrey & Christensen, 1972; Penick, et al., 1971; & Stuart, 1967). Harris and Brunner (1971) feel that personal contact with another individual encourages the subject to stay on the diet, lends emotional support, and helps the individual to clarify the requirements of the diet.

While Hagan's (1974) study demonstrated that a group using a behavior modification diet manual lost as much weight as another group

who used the same manual but were also treated by therapists, Fernan (1973) found that subjects who had therapist contact lost significantly more weight than subjects in other treatment programs. Abramson (1973), after reviewing 40 case reports and experimental studies of behavioral approaches to weight loss, suggested that self-control procedures were most promising when combined with therapist-controlled reinforcement. Voogt (1978) investigated how much therapist contact was optimum in producing the most weight loss with clients involved in a behavior weight loss program. He found that while there were no significant differences in weight loss among subjects who received counseling twice-a-week, once-a-week, and every-other-week, there was a significant difference between these treatment groups and a treatment group on the same diet program but with no counselor contact. This research points out the need for counselor contact, but indicates that every-other-week contact may be as effective as once-a-week or twice-a-week. These findings also suggest that counselors may be able to increase their caseload with this client population, while clients may find every-other-week counseling sessions more economical both in time and money.

The Weight Control Program

While much time could be spent discussing the pros and cons of various weight control programs attempted in the past, it is the purpose of this paper to suggest basic techniques that can be helpful in designing weight control programs in a variety of settings.

An important aspect of beginning a weight-control program is the requirement that all clients undergo a physical examination or obtain a physician's permission to participate. This basic first

step will make the client's physician aware of the client's involvement with a diet as well as alert the counseling staff to any metabolic disorders. Rarely do metabolic problems prohibit a client from participating or the diet from being successful. The physical examination indicates to the client that his/her overweight condition cannot be blamed on a faulty glandular system.

Prior to beginning the diet, clients should monitor their eating habits for one week to ten days (see Appendix A). This process establishes a baseline of their habits which enables them and the counselor to identify controlling situational variables and self-defeating behaviors such as excessive eating at certain periods during the day. Clients should record everything they eat, at what time, with whom, and their feelings during and after eating. Many clients are surprised at the maladaptive eating patterns they have developed over the years.

At the beginning of the diet program, the client's weight, height, and body frame size should be recorded. This helps to determine goals for the client in relationship to his/her ideal and present weight. If all of the clients can be brought together for an initial orientation meeting, it is highly recommended that a nutritionist be on hand to answer any questions.

Clients should be instructed in the use of a diet as well as in behavioral self-management techniques (see next section). The suggested diet, which was used in the study by Voogt (1978), is a 1,200-calorie Food Exchange Diet approved by the American Dietetic Association (see Appendix B). This diet supplies 67 grams of protein, 45 grams of fat, and 130 grams of carbohydrates.

Clients should keep a record of everything they consume daily on a standardized recording sheet (see Appendix C). In addition, they should record thoughts and feelings they experience while on the diet, and behaviors that contribute to maladaptive eating habits.

A schedule of individual counseling sessions should be developed for each client. It is suggested that every-other-week contact is sufficient to produce desirable weight loss. With this type of schedule, one can see that the client caseload can be dramatically increased.

Counselors should check the daily eating records of their clients in order to make certain that they understand the requirements of the prescribed diet. Counselors should reinforce clients for both weight loss and improved eating habits. If a client fails to lose weight, the counselor and client should explore ways of improving the client's adherence to the diet. Short-term and long-term goals for weight loss should be established. It is important for the counselor to be supportive of the client during the diet period, as that may be the client's only support at times. On occasion the client will reach a plateau in weight loss. If support is not present during these critical periods, clients often return to their former eating habits. A study by Greenberg (1977) demonstrated that for many individuals physical proximity to the counselor strengthened adherence to the diet. The problem encountered most in self-management programs that do not involve a significant other person is that the client fails to stick with the diet regimen. The counselor contact is often the only reason the client remains with the diet in the face of the numerous stimulations to abandon it.

What is it exactly that the counselor should be doing to help a client lose weight? As with any maladaptive habit, there is a reason behind the need to eat more than one needs. The number of psychological determinants of why people are overweight is extensive, but the most common seems to be an unmet need that eating seems to satisfy. It is difficult to distinguish, for example, between the hollowness in one's stomach caused by hunger and the hollowness caused by anxiety. Many individuals, thinking they are hungry, are experiencing some level of anxiety. In such cases, the counselor should help clients identify what is making them anxious. For other individuals, eating is simply a way of dealing with boredom. For still others, eating is a way of pleasing those who prepare food for them. The underlying factor here is that excessive caloric intake is simply a response to cues in the environment in relation to what a person thinks and feels about him/herself. In addition to monitoring the diet, then, the role of the counselor is to explore with the client what are the underlying factors that push the individual to eat, eat, eat

Self-Management Techniques for Weight Control

Listed below are specific self-management techniques that counselors should discuss with clients, either individually or in a group setting. It is suggested that all of the necessary diet information referred to in the last section, as well as information pertaining to the self-management techniques, be assembled in booklet form and distributed to clients. These techniques, used in the study by Voogt (1978) and based primarily on work done by Stuart and Davis (1972) and Jeffrey and Katz (1977), focus on reducing or eliminating behaviors that stimulate

maladaptive eating habits.

A. General Techniques

1. Keep daily record of food intake.
2. Keep daily record of appropriate eating habits.
3. Emphasize behavior change rather than weight loss.
4. Eat only in one specific spot when at home.
5. Sit while eating.
6. Take at least 20 minutes to eat a meal.
7. Leave something on the plate.
8. Plan a short delay before eating.
9. Swallow food before adding more to the eating utensil.
10. Plan a series of brief delays during meal or snack.
11. Keep extra food away from the table.
12. Clear table quickly after each course.
13. Chew slowly and thoroughly.
14. Measure food carefully.
15. Make only enough for one serving.
16. Leave table as soon as you have finished.
17. Re-arrange food supplies.
18. Keep weekly graph of weight change and behavior change.
19. Eat off smaller plates.
20. Turn off light bulb in refrigerator.
21. Eat according to a schedule, i.e., at a specific time.
22. If possible, eat in the company of another person.
23. Avoid impulsive buying of food (whether for immediate consumption or not); plan ahead of time what you are going to buy.
24. Don't leave goodies lying around the house, car, or office.

25. Don't eat to reduce anxiety. Keep to your schedule.

26. When you are nervous or anxious, don't let yourself be carried away by the mood of the moment. Rather, try to figure out why you are upset and deal with the cause directly or do muscle relaxation exercises.

27. Try to de-emphasize the importance of food in your life. Rather, place the emphasis on other aspects of your life, i.e., your growth as a person, your loved ones, your friends, your interests, etc.

28. Eat only nourishing foods; this is easily accomplished by sticking to the exchange diet.

29. Take advantage of your planning and check sheet. Plan use of exchanges.

30. Try drinking a glass of water before each meal.

31. Don't skip meals.

32. Don't try to compensate for a bad day. Forget it, and think about all those good days that you have had.

33. Set goals that will help accomplish those things that have been hanging over you; get rid of anxiety-producing situation.

34. Make a map of the supermarket to avoid problem areas.

35. If the rest of the family keeps problem foods around, isolate the foods on their own special shelf.

B. Techniques Useful During Snacks

1. Keep food out of all other rooms.

2. Slow down by cutting snacks into small pieces.

3. Choose higher caloric foods that require some preparation.

4. Keep lower caloric foods, useful for snacks, more available and visible than high caloric foods.

5. Have children and spouse make own snacks.

6. Change route in particular store if it is a problem.

7. Do not drop frequency of highly-preferred foods to zero.

8. When tempted to eat, refer to your list of alternative behaviors. It should suggest many equally enjoyable and important things for you to do.

C. Techniques Useful at Parties and in Restaurants

1. Sit at a distance from favorite snack foods.

2. Take your own diet pop and diet snacks.

3. Alternate alcohol with low caloric drinks.

4. Substitute lower caloric drinks for alcohol.

5. Add water to wine.

6. Keep basic technique of recording place and position.

7. Decide beforehand what you will order at a restaurant.

8. Take home a doggie bag.

9. Avoid long periods of deprivation prior to party or dining out.

10. When under social pressure to eat, assert your right not to eat; or if you wish to eat, do so sparingly.

11. Be proud of yourself each time that someone offers you something to eat and you say, "No, thank you."

D. Techniques to be Used Between Meals

1. Use incompatible behaviors to decrease habitual feelings of hunger.

2. Save or reschedule everyday activities for times when you are hungry.

3. Decrease frequency of food shopping.

4. Shop when not hungry.

5. Make a complete shopping list.

6. Use progressive muscle relaxation.

7. Remove all problem foods from house.

8. Use short-term rewards for behavior change.

9. Arrange home activities so that eating place is entered infrequently.

10. Involve the family or friends in your program.

E. Physical Activity

1. Park car farther away from destination.

2. Don't be too efficient; walk a little farther.

3. Get up early and walk for 15 minutes.

4. When in a building 3 stories or less, always use the stairway.

5. In all buildings, use the stairway when going down.

6. Use T.A.P. plan (Tap A Pal). Get a friend involved with you to make exercise more enjoyable.

7. Research recreational facilities and exercise opportunities available to you.

8. Replan daily activities so that more energy is expended.

Above All Else: MAKE YOUR WEIGHT LOSS PROGRAM RIGHT FOR YOU.
MAKE IT FUN AND MAKE IT REWARDING.

Exercise

With a proliferation of exercise clinics and health spas, one would think that losing weight would be easy. The truth is, however, that exercise alone is not the key. For example, running for ten minutes per day burns calories equivalent to about one beer or two medium apples. Running for thirty minutes per day burns up less calories than are contained in a four-ounce steak. This is not to minimize the use of exercise in a weight reduction program. However, individuals frequently tend to put total blame for their weight gain on lack of exercise. A study by Tooshi (1973) indicated that thirty minutes of jogging produced a significant reduction in resting, exercise, and recovery pulse rate in addition to significant reductions in skinful fat measures and body weight. Weight loss occurs when the body uses more energy than it has fuel for. In order for the body to

maintain a certain weight, one must burn exactly the number of calories that one takes in.

The Setting

A weight control program can be instituted in a variety of settings with a minimum of investment. The school is an ideal location for students who are in need of a structured weight-control program. Some students could be trained as peer counselors to work with their classmates. In the college and university setting, a weight-control program is a good way to attract clients to a practicum. Generally, clients bring to the counseling setting a wide variety of concerns in addition to their desire to lose weight. Community agencies, including employment agencies, would do well to have a weight-control program. The health as well as the job potential of clients would improve if they experienced weight loss.

Problems of Various Age Groups

Caloric requirements do not remain the same throughout the life span. A young child, for example, burns far more calories than an elderly person. Around the age of 16 to 18 years the metabolism of most females slows down about 8 to 11 percent. For males, this slowing down occurs between the ages of 24 and 27. That means that, if the activity level stays the same, the body requires that much less energy input (food) in order for people to maintain their present weight. As individuals grow older, their activity level ususally drops, and therefore the number of calories burned up each day decreases. This

becomes a particularly difficult problem when individuals are at middle age. Typically, by this time their incomes are such that they can afford foods which are more expensive but are also higher in calories (e.g., steak, which has high fat content). Contributing to the problem is their social life style--which may include cocktail parties, with the alcohol and snacks that are ordinarily a part of such events. There is also not as much demand for them to be involved as physically with their children as when the children were very young. Other complicating factors are that many middle-aged individuals are engaged in sedentary occupations, and their participation in active sports is also reduced. As people become elderly, their activities slow down and their food requirements decrease even more.

Many ask why young people seem to be fatter than they were 20 to 30 years ago. A simple explanation for this is that they tend to get less exercise--today almost everyone either rides a bike or travels in a car, both of which require less energy than walking. In addition, there has been an explosive increase in the number and availability of fast foods. As our society moves away from a tight family structure, more and more meals are eaten out in fast food restaurants, and the caloric count of most fast foods is typically much higher for the amount of nutritional value they provide than of foods prepared in the home.

What can be done about this problem? People need correct information regarding their nutritional requirements as they become older as well as the caloric count of the food they consume. This is especially important for commercially-made food products, as we are continuing to increase our intake of these types of food rather

than foods "made from scratch." Schools and public agencies should disseminate this type of information to the public if we are to make headway into this problem.

Problems of Special Populations

Besides issues dealing with the process of aging, problems of several special populations should be discussed as well.

One of the major groups whose eating habits need attention is individuals who are disabled, especially those who become disabled after childhood. For example, an active teenager who is involved in an accident that renders her quadriplegic will need much less caloric energy than she did before the accident. The problem is compounded in that time often moves more slowly when one is not active, and, as all of us know, many of us tend to eat when we become bored or lonely. Individuals in braces or fitted with prostheses need especially to watch their weight as any weight gain may make it impossible for them to use these adaptive aids. Whenever a dramatic change occurs in energy output, a similar change must occur in terms of caloric energy intake if individuals are to maintain appropriate body weight.

Other individuals are restricted in terms of the food they eat due to a variety of problems. These individuals need to consult a physician for a diet that will allow them to function properly and keep their weight at a normal level. In such cases it is imperative that there be communication among the referring counselor, the medical practitioner, and the family.

Another special group is pregnant women. Typically, physicians prescribe diets for them to ensure that the developing fetus will get the proper nutrition. A pregnant woman, however, cannot go on as strict a diet as a nonpregnant woman. Excessive weight gain can often complicate the pregnancy and delivery. In addition, after the child is born, the weight gained does not automatically disappear. The caloric requirements of a nursing mother are much greater than those of the mother who does not nurse her child. Again, the close supervision of a physician, nurse, or nutritionist is required.

Some individuals with whom counselors work concentrate heavily on food groups that are quite fattening, i.e., on carbohydrates rather than on protein. People with limited incomes often tend to buy foods which are inexpensive but highly caloric. Obviously, it is cheaper to fill up on a loaf of bread than on fresh meat, vegetables, or fruit. With the help of either a physician or nutritionist, the counselor should design a diet that will meet the needs of those individuals without greatly interfering with their particular culture or style of life. Most schools have nutritional consultants who can be called to help with these special problems. The types of foods available either because of economics, geographics, or culture will greatly affect the diet plan and the ability/desire of individuals to use it. The important thing is to be sensitive to these issues and to design diets that will meet individuals' needs in the best possible way.

In summary, to be truly helpful, counselors should gather available information about the cultural, economic, and physical conditions that play a part in the dietary habits and needs of their clients.

Little-Known Facts About Dieting

What is a pound really made of anyhow? Many individuals fail to realize that they need to eat 3,500 more calories than their body uses to gain one pound. The opposite of this is also true: They need to burn up 3,500 more calories than they take in to lose one pound. Thus, if an individual wanted to lose ten pounds, he/she would need to deprive his/her body of 35,000 calories. Consider the example of an individual who needs 2,000 calories daily to maintain a present weight of 160 pounds, and who desires to weigh 150 pounds. If that individual ate 1,500 calories per day instead of 2,000 calories per day, he/she would be burning up 500 calories of stored fat daily. At that rate, it would take the individual 70 days to lose 10 pounds (35,000 calories ÷ 500 calories = 70 days). This makes one wonder why it seems so easy to gain weight. If that same individual who needs 2,000 calories per day to maintain a 160-pound weight ate 2,100 calories per day (for example, 10 potato chips = 100 calories) he/she would gain one pound every 35 days or about ten pounds per year. This energy balance is a delicate phenomenon that deserves close attention.

Another major problem is that consumers have little knowledge of nutrition. Most do not realize, for example, that a breast of chicken has more protein than a three-ounce hamburger patty yet less than half the calories. Many also do not know that six baked potatoes have the same caloric content as one Big Mac hamburger, or that five slices of whole wheat bread are equivalent to a four-ounce steak. It is extremely important for clients to learn about nutrition and be knowledgeable about the calorie counts of various foods.

The body has a need for a variety of food, from all of the food groups. Interactions among foods from the various food groups make the optimum usage of each calorie. Therefore, a well-balanced diet is extremely necessary.

Some Misconceptions About Food and Dieting

Many "myths" about dieting contribute to people's failure to lose weight or to misunderstandings about proper methods of weight control. The following statements represent the most common misconceptions about food and dieting:

1. Brown eggs have a higher food value than white eggs.

2. Toasting reduces the calories in bread.

3. Protein is the most important nutritional need of the body.

4. You can eat and drink whatever you please if you take a vitamin and mineral capsule each day to assure a supply of essential nutrients.

5. It's natural to get fatter as you get older.

6. You can never eat too much protein.

7. If you have been overweight for a long time (e.g., since childhood), your problem is probably "medical" or hereditary.

8. Food eaten before you go to bed is more likely to cause weight gain than the same food eaten for breakfast.

9. Pork liver has more nutritive value than calf liver.

10. You can never drink too much milk.

11. Overweight people are generally happy, healthy people.

12. Because meat is a high protein food, it does not cause weight gain.

13. Beer is a good source of nutrients.

14. It makes no difference whether you eat fast or slowly.

15. It is better to lose weight as rapidly as possible rather than one pound at a time.

16. All fat and carbohydrates should be eliminated in a reducing diet.

17. Exercise increases the appetite.

18. You should drink less water while dieting.

19. The stomach shrinks during dieting.

20. Meal-skipping helps you to reduce.

21. You should expect to feel weak and fatigued during weight reducing.

Failure to Lose Weight

The most famous line uttered by individuals who are dieting is, "I didn't lose one pound even though I was on a diet for months!" Why are some clients able to stay with a diet better than others? A discussion was held with the counselors in the study by Voogt (1978) immediately after the end of the research project to attempt to find answers to this question. The statements that follow represent their thinking.

Losing a great deal of weight at the beginning of a diet appears to reinforce clients immediately and encourages them to continue with the diet. Persons who lose weight a little more slowly appear to lose their initial drive. This is the major reason why continual counselor contact is necessary, especially at a time when individuals reach a plateau in their weight loss.

Some clients rationalize their overeating, especially in social situations. They offer no resistance to social pressure to overeat, often thinking they may insult the host or hostess by eating less.

Some clients hide the fact from their partners that they are on a diet, fearing that their partners will ridicule them for making another futile attempt to lose weight. Others may have no significant other besides the counselor to encourage them to lose weight.

Clients who appear to have a high self-concept seem to work harder at losing weight and to accomplish their goals more readily. Those with a lower self-concept tend to blame others, such as overweight parents, for their weight condition.

A final thought has to do with where clients eat their meals. Those who have complete control of their own cooking seem to stay with the diet more easily than those who eat in restaurants. Individuals often have difficulty resisting foods on the menu that their diet does not allow. In addition, if the restaurant portions exceed those allowed on the diet, the client, although feeling guilty, eats everything as it would be "wasteful" to leave any food on the plate. Some blame the restaurant for giving them too much food.

These findings are presented so that counselors will be prepared for some of the problems they may encounter in working with overweight clients. While this does not exhaust the list of reasons why people fail to lose weight, these problems are among those commonly found in weight control programs.

The New Person

Achieving desired weight loss does not end the client's need for assistance. It is this author's contention that it is as critical for the counselor to deal with the new thinner version of the person as with the former fat person. Voogt (1978) found that some mates

of partners who lost weight encouraged their mates to gain the weight back! They often brought home high-calorie foods for their spouse. Some mates became jealous of new attentions given to their partners--especially by members of the opposite sex. The slimmer figure was a threatening situation for the dieter's partner. Some overweight partners disliked the fact that their spouses had the ability to lose weight. They seemed to feel that their "partners in crime" were forsaking their "pact" to be overeaters. Clearly, significant weight loss can be extremely disruptive to some individuals and/or to a partnership.

Even after working so hard to achieve weight loss, some clients fail to enjoy their new look, as they now have lost a major excuse for staying aloof socially. For some, the overweight condition is an effective excuse for avoiding dating, marriage, dancing, and athletics, as well as jobs requiring public exposure.

The new person's self-concept also becomes vulnerable. If we believe that body image affects self-concept, then we must recognize that changing body image will have an impact on self-concept. Losing weight does not necessarily mean that clients will now think of themselves as being more attractive or more desirable to their friends or significant others. Most clients who have lost weight cling to the notion that they are heavy and unattractive physically. After thinking of themselves in this way for so long, many clients find it difficult to change that mind set, even after their bodies change.

The counselor should continue working with clients beyond the time their goals have been reached. Rehabilitation of the body does not guarantee that the mind will have changed in ways to cope effectively

with the new look. This follow-up period will do much to insure that clients will keep weight off, and will be able to adjust to their new image.

Some Final Thoughts

This brief paper has offered what are hoped to be helpful suggestions to counselors who work with clients desiring to lose weight. Especially useful should be the diet included as Appendix B, as well as the specific techniques listed in the body of the manuscript. Clearly, weight control is a serious issue that needs attention from counselors--challenging, to be sure, yet measurable in terms of results. Counselors who can deal with the issues of obesity will be better prepared to meet the challenges of the eighties.

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Appendix A

Eating Baseline and Frequency Chart

An eating baseline is a measurement of your current eating patterns--so do not change what you are doing at this time, but write it down. That means write everything down. This baseline will provide us with information we must have to develop not only your diet plan, but a strategy for changing personal environmental factors which are contributing to the fact that you are overweight. This baseline must be kept every day beginning on _____, starting with the first morsel that enters your mouth until the last one on _____, which is the starting day of the diet training. That means you must keep a record of seven days on the baseline. Remember, you must write down everything you eat, as well as when, where, with whom, what you are doing, and your thoughts and feelings while eating.

Included in this packet of baseline information are the following items:

1. Seven eating baseline forms

   --Use one form every day starting _____ and continuing through next _____. (Example: Friday . . . through . . . Thursday.)

   --Each time you eat something, record the relevant information in each column.

2. Instructions and forms for analyzing your data at the end of each day.

Instructions for Analyzing Your Data at the End of the Day

Please refer to your completed Eating Baseline form and answer the following questions (on the proper form, please) at the end of each day.

--How many times you ate each day and when. (Answer on the frequency chart; see example.)

--How many of the symbols (*, △, □, 0) were found on your Eating Baseline each day.

--What people you were with and what locations you were in when you ate.

--What your most frequent thoughts and feelings were while eating.

EATING BASELINE

Name: Date:

Time Began	Time Ended	What Eaten	Quantity	With Whom	Where and Doing What	Thoughts and Feelings

* Put an asterisk next to the Time Began if you were hungry.
Δ Put a triangle next to the Time Ended if you were uncomfortably full.
□ Put a square around any quantity which was more than enough to be satisfying.
O Circle any food which contributes regularly to your overweight condition.

FREQUENCY CHART

Example

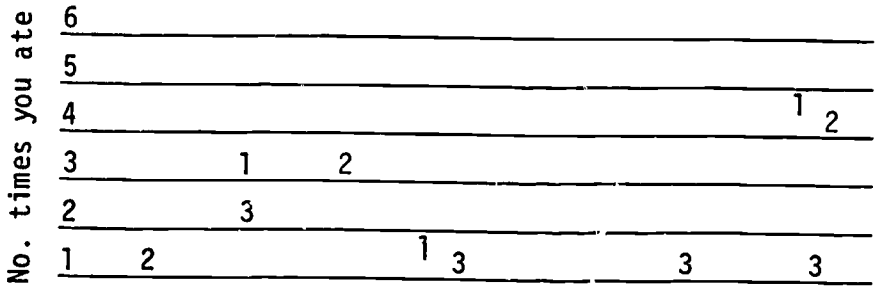
(after first 2 days have been completed)

If Your Eating Baseline Looks Like This:

Day #3

Time Began	Time Ended	What Eaten . . .
7:15	*7:25*	*Black Coffee*
7:50	*7:58*	*Cereal, Milk*
9:30	*9:35*	*Orange*
11:55	*12:10*	*Ham Sandwich, Coke*
12:47	*12:55*	*Candy Bar*

Then Your Frequency Chart Might Look Like This:



On day 3 you ate: twice from 7 till 8, once from 9 till 10, etc.

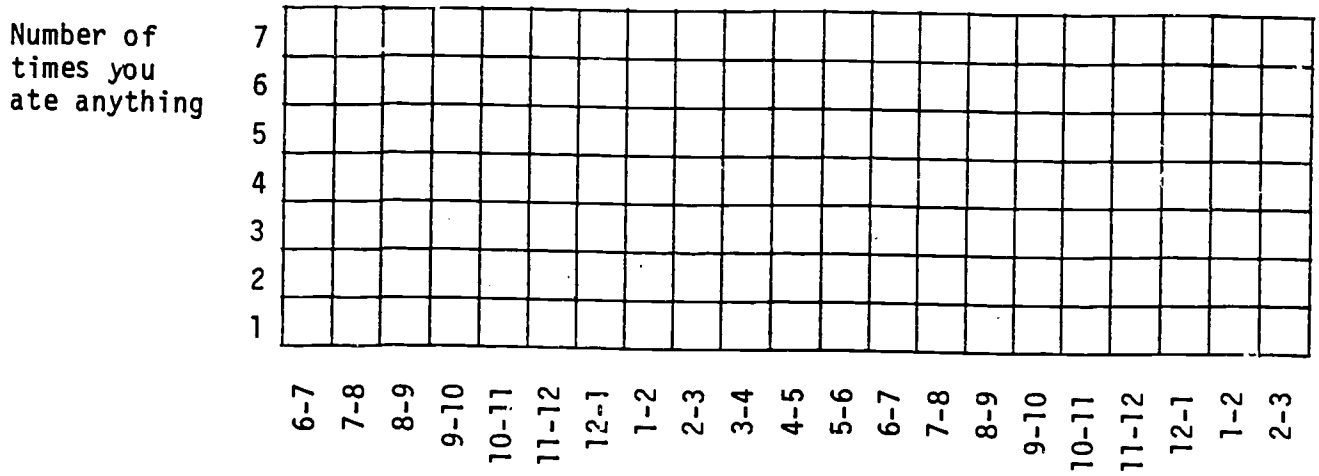
6-7 7-8 8-9 9-10 10-11 11-12 12-1

Hours of the Day

See following pages for the rest of the charts. Please be accurate and complete.

Fill in Daily

FREQUENCY CHART



Record how many of the following symbols you found on your Eating Baseline each day:

	1	2	3	4	5	6	7	8	9	10
*										
△										
□										

○ Which food items did you circle? List below.

Add to the boxes each day the names of the people you were with and the locations you were in when you ate.

	Acceptable Foods	Unacceptable Foods
People		
Locations		

What were the most frequent thoughts and feelings you experienced while eating?

	Pleasant	Unpleasant
Thoughts		
Feelings		

Thank you for completing this analysis. We hope you have learned some new things about yourself.

Appendix B

FOOD EXCHANGE DIET

The food exchange diet, as approved by the American Dietetic Association, the American Medical Association, and the American Heart Association, is nutritionally sound, flexible, and easy to follow.

In the food exchange diet, all foods are classified into seven groups: (1) milk; (2) vegetables; (3) fruits; (4) breads; (5) meats; (6) beverages, fats, and sweets; and (7) unlimited free foods. The foods within each group are approximately the same in nutrients and calories.

Each meal plan recommends a number of foods from each group, thus ensuring a balanced diet. Within each food group a person can interchange any foods according to personal preference or need, allowing a person maximum flexibility and choice. While foods within the same group may be exchanged, foods from different groups should not be substituted. For a list of food exchange groups refer to the section entitled "Exchange Diet Food Groups."

The Daily Eating Record (Appendix C) should be filled in after each intake of food or drink. The maximum caloric intake on this diet is 1,200 calories per day. In order to fulfill the requirements of the diet, the food exchanges on the next page are recommended.

1,200 Calorie Food Exchange Diet

Protein - 67 grams
Fat - 45 grams
Carbohydrate - 130 grams

Food Exchange Group	Breakfast	Lunch	Dinner	Snack
1. Milk exchange 80 calories	1			1
2. Vegetable exchange a. Free vegetables (AA) b. 25 calories (1/2 cup)	AA	AA 1	AA 2	AA
3. Fruit exchange 40 calories	1	1	1	
4. Bread exchange 70 calories	1	1	2	
5. Meat exchange 75 calories (low fat) Note: For each exchange of high fat, omit one fat exchange	1	1	3	
6. High calorie fats, sweets, and beverages exchange 45 calories	1	1	1	1
7. No calorie-unlimited 0 calories	AA	AA	AA	AA

AA - indicates any amount may be eaten.

Exchange Lists

This diet groups foods by their nutrient value. The first group is the Milk Exchange group. Skimmed milk or nonfat milk is recommended and is measured as 1 cup (8 ounces or 1/2 pint). Notice that not all milks are used in the same amount. Powdered milk is measured as a powder (1/3 cup) and mixed with water to make one cup of fluid milk. Observe, also, that if milks with fat content are used, you must spend one or two fat exchanges from your allowance.

Group 2 is the Vegetable Exchange group. All vegetables are measured as 1/2-cup portions. Some raw vegetables may be eaten freely in any quantity. In addition to the vegetables, seasonings and low-cal beverages may be used without restriction.

The Fruit Exchange group shows how much of one fruit or fruit juice may be substituted for another. Note that all fruits or juices are to be either fresh or dried or prepared without sugar.

The Bread Exchange group includes bread, such as whole wheat, rye, pumpernickel, vienna, white, etc., but does not include sweet-breads (banana, pumpkin, cranberry, etc.). You may select a small dinner roll. If you use a bagel or a hamburger bun, note that it would count for two bread exchanges. Cereals, rice, pasta, or crackers may also be used as a substitute for bread. Starchy vegetables are used as bread substitutes. A number of prepared items may be used instead of bread, but are higher in fat content. Therefore, you must spend one or two fat exchanges if you use them.

The Meat Exchange group is divided into three sections; those which are lean come first. Keep in mind that the weights which are given for meat, poultry, and fish are "cooked weights," after the visible fat

is trimmed off. Meat loses about 25% of its weight when cooked. Thus, a 4-ounce portion of raw, boneless meat would yield 3 ounces or 3 exchanges when cooked. An 8-ounce, raw chicken quarter would yield 3 ounces of cooked chicken. For each exchange used from this group, you may add 1/2 exchange to your fat group. These meats are preferred because they are lower in saturated fat.

The medium-fat meat group is treated the same as the lean-meat group except that no adjustment is made in the fat exchanges. With the high-fat meats, you must spend 1 fat exchange along with each meat exchange.

The last group is the Fat Exchange group. You may use margarine, butter, nuts, or salad dressings. Remember that adjustments must be made in this group if you use items which are higher or lower in fat.

Dietetic foods are not recommended, except for those listed: artifical sweeteners and diet, calorie-free beverages. Labeling a food "dietetic" may mean that it is low carbohydrate, or it may mean low salt, low fat, or low cholesterol. Some dietetic foods contain a sweetener such as sorbitol or manitol which is a carbohydrate and does yield calories.

Exchange Diet Food Groups

Each item equals one unit or exchange in its group.

1. 1 cup of vegetables equals 1 bread exchange.
2. 1 bread exchange equals 1-1/2 servings of fruit.

Special Note on Alcohol

Alcohol may be substituted once or twice a week. Use only two drinks at any time.

12 oz. beer = 1 bread exchange and 2 fat exchanges

2-1/2 oz. dry wine = 1 bread exchange and 1 fat exchange

1 oz. hard liquor = 2 fat exchanges

1. Milk Exchange

The items with an asterisk are nonfat.

*Nonfat fortified milk:	
*Skim or nonfat milk	1 cup
*Powdered (nonfat dry, before adding liquid)	1/3 cup
*Canned, evaporated--skim milk	1/2 cup
*Buttermilk made from skim milk	1 cup
*Yogurt made from skim milk (plain, unflavored)	1 cup
Low fortified milk:	
1% fat fortified milk (omit 1/2 fat exchange)	1 cup
2% fat fortified milk (omit 1 fat exchange)	1 cup
Yogurt made from 2% fortified milk (plain, unflavored) (omit 1 fat exchange)	1 cup
Whole Milk (omit 2 fat exchanges):	
Whole milk	1 cup
Canned, evaporated whole milk	1/2 cup
Buttermilk made from whole milk	1 cup
Yogurt made from whole milk (plain, unflavored)	1 cup

2. Vegetable Exchange (1/2 cup)

Unless cooked with fat, all vegetables are nonfat.

Asparagus
Bean sprouts
Beans, green or yellow
Beets
Broccoli
Brussels sprouts
Cabbage
Carrots
Cauliflower
Celery
Chilis
Cucumbers
Eggplant
Mushrooms
Okra
Onions
Peppers
Rhubarb
Rutabaga
Sauerkraut
Spinach and other greens
Summer squash
Tomatoes
Tomato juice
Turnips
Vegetable juice cocktail
Zucchini

The following raw vegetables are all free exchanges and may be eaten in any amounts:

Chicory	Lettuce
Chinese cabbage	Parsley
Endive	Radishes
Escarole	Watercress

Starchy vegetables are found in the bread exchange list.

Free Foods:

There are some foods that you won't find on the exchange lists. Salt, pepper, herbs, spices, parsley, lemon, horseradish, vinegar, mustard, celery salt, onion salt or powder, garlic, and bottled hot pepper sauce are all flavor bonuses with a "free" exchange rating. Diet calorie-free beverages, tea, coffee, nonfat bouillon, unsweetened gelatin, and unsweetened pickles are free, too.

3. Fruit Exchange

Fruits are all nonfat.

Apple	1 small
Apple juice or cider	1/3 cup
Applesauce (unsweetened)	1/2 cup
Apricots, fresh	2 medium
Apricots, dried	4 halves
Banana	1/2 small
Berries:	
Strawberries	3/4 cup
Other berries	1/2 cup
Cherries	10 large
Dates	2
Figs, fresh or dried	1
Grapefruit	1/2
Grapefruit juice	1/2 cup
Grapes	12
Grape juice	1/4 cup
Mango	1/2 small
Melon:	
Cantaloupe	1/4 small
Honeydew	1/8 medium
Watermelon	1 cup
Nectarine	1 small
Orange	1 small
Orange Juice	1/2 cup
Papaya	3/4 cup
Peach	1 medium

Fruit Exchange (continued)

Pear	1 small
Persimmon, native	1 medium
Pineapple	1/2 cup
Pineapple juice	1/3 cup
Plums	2 medium
Prunes	2 medium
Prune juice	1/4 cup
Raisins	2 tablespoons
Tangerine	1 medium

Cranberries may be used as desired if no sugar is added.

4. Bread Exchange

The asterisked items are lowfat bread exchanges.

*Bread:	
*White, whole wheat, rye, pumpernickel, or raisin	1 slice
*Bagel, small	1/2
*English muffin, small	1/2
*Plain roll, bread	1
*Frankfurter roll	1/2
*Hamburger bun	1/2
*Dried bread crumbs	3 tablespoons
*Taco shell	1
*Cereal:	
*Bran flakes	1/2 cup
*Other ready-to-eat unsweetened cereal	3/4 cup
*Puffed cereal (unfrosted)	1 cup
*Cereal (cooked)	1/2 cup
*Grits (cooked)	1/2 cup
*Rice or barley (cooked)	1/2 cup
*Pasta (cooked)	1/2 cup
*Popcorn (popped, no fat added)	3 cups
*Cornmeal (dry)	2 tablespoons
*Flour	2-1/2 tablespoons
*Wheat germ	1/4 cup
*Crackers:	
*Arrowroot	3
*Graham, 2-1/2 inch	2
*Matzo, 6 x 4 inch	1/2
*Oyster	20
*Pretzels, 3-1/8 inches long, 1/8 inch diameter	25

Bread Exchange (continued)

*Rye wafers, 3 1/2 x 2	3
*Saltines	6
*Soda, 2-1/2 inch square	4
*Dried Beans, Peas, and Lentils:	
*Beans, peas, lentils (dried, cooked)	1/2 cup
*Baked beans, no pork (canned)	1/4 cup
*Starchy Vegetables:	
*Corn	1/3 cup
*Corn on cob	1 small
*Lima beans	1/2 cup
*Parsnips	2/3 cup
*Peas, green (canned or frozen)	1/2 cup
*Potato, white	1 small
*Potato (mashed)	1/2 cup
*Pumpkin	3/4 cup
*Winter squash	1/2 cup
*Yam or sweet potato	1/4 cup
Prepared Foods:	
Biscuit, 2-inch diameter (omit 1 fat exchange)	1
Corn bread, 2 x 2 x 1-inch (omit 1 fat exchange)	1
Crackers, round butter type (omit 1 fat exchange)	5
Muffin, plain small (omit 1 fat exchange)	1
Potatoes, french-fried (omit 1 fat exchange)	8
Potato or corn chips (omit 2 fat exchanges)	15
Pancake, 5 x 1/2-inch (omit 1 fat exchange)	1
Waffle, 5 x 1/2-inch (omit 1 fat exchange)	1

Miscellaneous

Coffee creamers	2 tablespoons
Jello	1/3 cup
Sponge or Angel cake (no icing)	1-1/2" cube
**Ice cream	1/2 cup
*Ice milk	1/2 cup
Sherbet	1/4 cup
Ice cream cone	1

*--Omit 1 fat exchange
**--Omit 2 fat exchanges

5. Meat Exchange

All lean meats are low in saturated fat and cholesterol. Gain 1/2 fat exchange for every lean meat exchange.

Beef: Baby Beef (very lean), Chipped Beef, Flank Steak, Tenderloin, Steaks (Sirloin and T-Bone, trimmed), Plate Ribs, Plate Skirt Steak, Round (bottom, top), all cuts Rump, Tripe	1 ounce
Lamb: Leg, Rib, Sirloin, Loin, Shank, Shoulder	1 ounce
Pork: Leg (whole rump, center shank), Ham, smoked (center slices)	1 ounce
Veal: Leg, Loin, Rib, Shank, Shoulder, Cutlets	1 ounce
Poultry: Meat without skin of Chicken, Turkey, Cornish Hen, Guinea Hen, Pheasant	1 ounce
Fish: Any fresh or frozen canned Salmon, Tuna, Mackerel, Crab, Lobster, Clams, Oysters, Scallops, Shrimp,	5 or 1 ounce
Sardines, drained	3
Cheeses containing less than 5% butterfat	1 ounce
Cottage cheese, dry and 2% butterfat	1/4 cup
Dried beans and peas (omit 1 bread exchange)	1/2 cup

Medium-Fat Meat Exchange

Each serving listed below is for cooked meat and counts as 1 Medium-Fat Meat Exchange. The asterisked items are low in saturated fat and cholesterol.

Beef: Ground (15% fat), Corned Beef (canned), Rib Eye, Round (ground commercial)	1 ounce
Pork: Loin (all cuts tenderloin), Shoulder Arm (picnic), Shoulder Blade, Boston Butt, Canadian Bacon, Boiled Ham	1 ounce
Variety Meat: Liver, Heart, Kidney, and Sweetbreads (high in cholesterol)	1 ounce
Cottage Cheese, creamed	1/4 cup

Medium-Fat Meat Exchange (continued)

Cheese: Mozzarella, Ricotta, Farmer's Cheese, Neufchatel, Parmesan	1 ounce
Egg (high in cholesterol)	1
*Peanut Butter (omit 2 additional fat exchanges)	2 tablespoons

High-Fat Meat Exchange

Each serving below is for cooked meat and counts as 1 High-Fat Meat Exchange. Lose 1/2 Fat Exchange for every High-Fat Meat Exchange.

Beef: Brisket, Corned Beef (brisket), Gound Beef (more than 20% fat), Hamburger (commercial), Chuck (ground commercial), Roasts (rib), Steaks (club, rib)	1 ounce
Lamb: Breast	1 ounce
Pork: Spareribs, Loin (back ribs), Pork (ground), Country-style Ham, Deviled Ham	1 ounce
Veal: Breast	1 ounce
Poultry: Capon, Duck (domestic), Goose	1 ounce
Cheese: Cheddar types	1 ounce
Cold Cuts	4-1/2 x 1/8-inch slice
Frankfurter	1 small

6. Fat Exchange

Foods that appear with asterisk are polyunsaturated.

Margarine, soft, tub, or stick	1 teaspoon
Margarine, regular stick	1 teaspoon
*Avocado (4-inch diameter)**	1/8
Butter	1 teaspoon
Bacon Fat	1 teaspoon
Bacon, crisp-cooked	1 strip
Cream, light or sour	2 tablespoons
Cream, heavy	1 tablespoon
Cream Cheese	1 tablespoon
French or Italian Dressing***	1 tablespoon
Lard	1 teaspoon
Mayonnaise***	1 teaspoon
*Nuts:	
Almonds**	10 whole
Pecans**	2 large whole

Fat Exchange (continued)

Peanuts**	
Spanish	20 whole
Virginia	10 whole
Walnuts	6 small
Other**	6 small
*Oil: Corn, Cottonseed, Safflower, Soy, Sunflower, Olive**, Peanut**	1 teaspoon
*Olives**	5 small
Salad dressing, mayonnaise type***	2 teaspoons
Salt Pork	3/4-inch cube

*Made with corn, cottonseed, safflower, soy, or sunflower oil only.
**Fat content is primarily monounsaturated.
***If made with corn, cottonseed, safflower, soy, or sunflower oil, can be used on fat modified diet.

Appendix C

DAILY EATING RECORD

Diet Plan	Breakfast Foods	Exch.	Lunch Foods	Exch.	Dinner Foods	Exch.	Snack Foods	Exch.
Meat Bread "B" Veg Fruit Fat Milk								
Meat Bread "B" Veg Fruit Fat Milk								
Meat Bread "B" Veg Fruit Fat Milk								
Meat Bread "B" Veg Fruit Fat Milk								

Daily Eating Record (continued)

Diet Plan	Breakfast Foods	Exch.	Lunch Foods	Exch.	Dinner Foods	Exch.	Snack Foods	Exch.
Meat Bread "B" Veg Fruit Fat Milk								
Meat Bread "B" Veg Fruit Fat Milk								
Meat Bread "B" Veg Fruit Fat Milk								

If you go over the recommended amount on any day, please indicate that at the end of the day.